Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

www.dmas.virginia.gov

MEDICAID MEMO

TO: All Virginia Medicaid Participating Healthcare Providers and Managed Care Organizations (Excluding Dental Providers)

FROM: Patrick W. Finnerty, Director
Department of Medical Assistance Services

MEMO: Special

DATE: 8/7/2007

SUBJECT: Integration of Acute and Long Term Care Services – Phase I

Governor Timothy Kaine, with support from the 2006 General Assembly, set in motion a major reform of the Virginia Medicaid funded long-term care services program, which will focus on care coordination and integration of acute and long-term care services for our most vulnerable citizens—low-income seniors and individuals with disabilities.

Currently, more than 49,000 elderly and persons with disabilities (who are Medicaid only) have their health care needs successfully managed by one of five Medicaid contracted managed care organizations (MCOs) serving 110 localities across Virginia. However, once these recipients become eligible to participate in a home-and-community based waiver, they are moved out of a managed care environment and into Fee-for-Service. This disruption in care does not promote continuity of care for the enrollee and is costly for the Commonwealth.

Effective September 1, 2007, DMAS will commence with the integration of Acute and Long Term Care Services (Phase I). As part of the program, once a Medicaid managed care enrollee is approved for enrollment into a Medicaid home-and-community based waiver (excluding those enrolled into the Technology Assisted Waiver), they will remain in their assigned MCO for their medical services, and transportation to medical appointments. Their home-and-community based care waiver services, including transportation to the waivered services, will be paid through the Medicaid Fee-For-Service program as a "carved out" service. This program change will prevent enrollees from having to change from their current MCOs for their medical care and will eliminate disruptions in care. Phase I will impact approximately 500 enrollees per year.

Please refer to the attached FACT SHEET for detailed information on the program.

HOME-AND-COMMUNITY BASED WAIVER SERVICES PROVIDERS

All current home-and-community based waiver enrollment and prior authorization service requirements processes and limitations will remain in effect.

VERIFY CLIENT ELIGIBILITY

Providers are encouraged to verify the recipient's eligibility to avoid unnecessary delays associated with prior authorization submissions to an incorrect payer source. The prior authorization processes currently in place will remain the same.

DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification. The website address to use to enroll for access to this system is http://virginia.fhsc.com.

The MediCall voice response system will provide the same information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Providers may also access prior authorization information including status via iEXCHANGE at http://dmas.kepro.org/.

QUESTIONS

DMAS is working to make the transition to the program as seamless as possible for recipients and providers. In order to facilitate this transition, DMAS will hire two designated staff members to address any questions or issues that arise regarding authorization, coverage, and provision of services, and to work with the MCOs to coordinate care between providers and the MCOs.

Questions about the program also may be sent via email to ALTC@dmas.virginia.gov. Information is posted on the DMAS website at http://www.dmas.virginia.gov/altc-home.htm. The Department will post and continually update Frequently Asked Questions (FAQs) for providers and recipients at this webpage.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:30 a.m. to 4:30 p.m., except on state holidays. The "HELPLINE" numbers are:

1-804-786-6273 Richmond area and out-of-state long distance
1-800-552-8627 All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

COPIES OF MANUALS

DMAS publishes electronic and printable copies of its Provider Manuals and Medicaid Memoranda on the DMAS website at www.dmas.virginia.gov. Refer to the "DMAS Content Menu" column on the left-hand side of the DMAS web page for the "Provider Services" link, which takes you to the "Manuals, Memos and Communications" link. This link opens up a page that contains all of the various communications to providers, including Provider Manuals and Medicaid Memoranda. The Internet is the most efficient means to receive and review current provider information. If you do not have access to the Internet or would like a paper copy of a manual, you can order it by contacting Commonwealth-Martin at 1-804-780-0076. A fee will be charged for the printing and mailing of the manuals and manual updates that are requested.

PROVIDER E-NEWSLETTER SIGN-UP

DMAS is pleased to inform providers about the creation of a new Provider E-Newsletter. The intent of this electronic newsletter is to inform, communicate, and share important program information with providers. Covered topics will include changes in claims processing, common problems with billing, new programs or changes in existing programs, and other information that may directly affect providers. If you would like to receive the electronic newsletter, please sign up at www.dmas.virginia.gov/pr-enewsletter.asp.

Please note that the Provider E-Newsletter is not intended to take the place of Medicaid Memos, Medicaid Provider Manuals, or any other official correspondence from DMAS.

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ALTC Phase I Fact Sheet

Purpose	Under Phase I, Virginia Medicaid recipients already enrolled with a managed care organization (MCO), who are Medicaid only, and who subsequently become enrolled into one of six home-and-community based waivers will continue to receive their acute and primary medical care via their assigned MCO. This change will become effective September 1, 2007.
Services Offered	Under the new program, recipients will remain in the MCO for their primary medical care services. Their home-and-community based care waiver services will be carved out and will be paid through the Medicaid fee for service program. Transportation to medical appointments shall be arranged and paid for by the assigned MCO. Transportation to waiver services shall be arranged by LogistiCare and paid for by DMAS. Dental services and community rehabilitative services shall remain as carved out services.
Who is Eligible?	This change will affect only Virginia Medicaid recipients already enrolled with a MCO who subsequently become enrolled into any of the following six home and community based waivers (HCBW): • HIV/Aids Waiver; • Mental Retardation (MR) Waiver; • Day Support Waiver; • Elderly or Disabled with Consumer-Direction Waiver; • Alzheimer's Assisted Living Waiver; • Individuals and Families with Developmental Disabilities (DD) Waiver This change does not apply to: • Recipients in the Technology Assisted Waiver • Recipients placed in a waiver before becoming enrolled into managed care • Dual Eligibles (receiving Medicare and Medicaid) • HIPP Enrollees • PACE Recipients • Nursing Facility Residents • FAMIS Enrollees

Service Requirements and Limitations	All current service requirements and limitations remain in place, including prior authorization requirements. Prior authorization (PA) will continue as follows: • MCOs shall PA acute and primary medical care services, pharmacy related services, and transportation to medical appointments. • KePRO shall process waiver enrollments and prior authorize services for the AIDS and EDCD waivers. • DMAS shall process waiver enrollments for the DD waiver and KePRO shall prior authorize services for this waiver. • DMAS shall process waiver enrollments and prior authorize services for the Alzheimers waiver. • DMHMRSAS shall process waiver enrollments and prior authorize services for the MR and Day Support waivers. • Doral Dental shall PA all dental related services. • LogistiCare shall PA all waiver related transportation services. • PPL shall process consumer directed timesheets and payroll.
Enrollment Process	• Recipients enrolled in a MCO and who are subsequently enrolled into a HCBW (other than the Technology Assisted Waiver) with a start of care on or after September 1, 2007, will remain enrolled in the MCO. • Recipients enrolled in a MCO as of September 1, who enroll in the Technology Assisted Waiver on or after September 1 will continue to be exempt from MCO enrollment. • Recipients enrolled in a MCO as of September 1 but whose waiver enrollment is entered prior to September 1, will be exempted from managed care enrollment. • Recipients who are not enrolled in a MCO (on or after September 1) at the time they enter HCBW services will remain exempt from managed care enrollment. {Rule of thumb to remember – Recipient must be in a MCO prior to enrollment into a waiver before they can *maintain* their MCO enrollment.}
Claims Information	All current claims processing systems remain in place. The MCO will continue to cover the same contracted medical services and transportation to contracted medical appointments. The current managed care carved out services (dental, school health, etc.), including the HCBW services will continue to be handled through fee-for-service. DMAS fee-for-service will continue to pay for the waiver services and transportation to waiver services.
DMAS Contacts	**Email:** ALTC@dmas.virginia.gov **Medicaid Eligibility/Claims Inquiries:** Eligibility or claims status may be checked via http://virginia.fhsc.com or MediCall voice response system at 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.
MCO Contacts	AMERIGROUP 1-800-600-4441 Anthem 1-800-901-0020 or 1-757-326-5090 CareNet 1-800-279-1878 Optima Family Care 1-800-881-2199 or 1-757-552-8975 Virginia Premier 1-800-828-7953 (Tidewater); 1-800-289-4970 (Richmond/Central/Western); 1-888-338-4579 (Southwest)

Integration of Acute and Long Term Care (ALTC)
Phase I
Frequently Asked Questions
Providers

What is Phase I of the Integration of Acute and Long Term Care (ALTC)?

Currently, more than 49,000 elderly and persons with disabilities have (who are Medicaid only) their health care needs successfully managed by one of five Medicaid contracted managed care organizations (MCOs) serving 110 localities across Virginia. However, once these recipients become eligible to participate in a home and community based waiver, they are moved out of a managed care environment into a fragmented fee for service environment with little coordination of their health care and long-term care needs. This disruption in care does not promote continuity of care for the enrollee and is costly for the Commonwealth.

Effective September 1, 2007, once a Medicaid managed care enrollee is approved for enrollment into a Medicaid home and community based waiver (excluding those enrolled into the Technology Assisted Waiver), they will remain in their assigned MCO for their medical services, and transportation to medical appointments. Their home-and-community based care waiver services, including transportation to the waivered services, will be paid through the Medicaid fee for service program as a "carved out" service. This program change will prevent enrollees from having to change from their current MCOs for their medical care and will eliminate disruptions in care. Phase I will impact approximately 500 enrollees per year.

Which enrollees are impacted by this change?

This change will affect only Virginia Medicaid recipients already enrolled with a MCO who subsequently become enrolled into any of the following six home and community based waivers:

- HIV/Aids Waiver;
- Mental Retardation (MR) Waiver;
- Day Support Waiver;
- Elderly or Disabled with Consumer-Direction Waiver;
- Alzheimer's Assisted Living Waiver;
- Individuals and Families with Developmental Disabilities (DD) Waiver.

This change does not apply to:

- Recipients in the Technology Assisted Waiver
- Recipients placed in a waiver before becoming enrolled into managed care
- Dual Eligibles (receiving Medicare and Medicaid)
- HIPP Enrollees
- PACE Recipients
- Nursing Facility Residents
- FAMIS Enrollees

When will the program become effective?

Phase I will become effective September 1, 2007.

How will the process be different?

Under the new program, recipients will remain in their assigned MCO for their primary and acute medical care services. Their home and community based care waiver services will be carved out and paid through the Medicaid fee for service program.

Transportation to HCBW services will be provided by DMAS through the fee-for-service program. Transportation to acute and other health care services will continue to be the responsibility of the MCO.

The integration of the acute and long term care programs will take place as follows:

- Recipients enrolled in a MCO and who are subsequently enrolled into a HCBW (other than the Technology Assisted Waiver) with a start of care on or after September 1, 2007, will remain enrolled in the MCO.
- Recipients enrolled in a MCO as of September 1, who enroll in the Technology Assisted Waiver on or after September 1 will continue to be exempt from MCO enrollment.
- Recipients enrolled in a MCO as of September 1 but whose waiver enrollment is entered prior to September 1, will be exempted from managed care enrollment.
- Recipients who are not enrolled in a MCO (on or after September 1) at the time they enter HCBW services will remain exempt from managed care enrollment.

{Rule of thumb to remember – Recipient must be in a MCO prior to enrollment into a waiver before they can *maintain* their MCO enrollment.}

How will providers be able to identify these recipients?

This process should remain seamless for providers of acute and primary medical services. DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification. The website address to use

to enroll for access to this system is http://virginia.fhsc.com. The MediCall voice response system will provide the same information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Providers also may contact the recipient's assigned MCO for eligibility verification.

How do recipients access transportation to medical and/or waiver services?

If the recipient needs transportation to a medical appointment, they should contact the number listed on their assigned MCO card.

If the recipient requires transportation to an approved waiver related service, they should contact LogistiCare at 1-866-386-8331.

Who do providers bill for services?

The MCO will continue to cover the same contracted medical services and transportation to contracted medical appointments. The current managed care carved out services (dental, school health, etc.), including the HCBW services will continue to be handled through fee-for-service.

DMAS fee-for-service will continue to pay for the waiver services and transportation to waiver services.

Is there any change to the prior authorization process?

No. Prior authorization (PA) will continue as follows:

- MCOs shall PA acute and primary medical care services, pharmacy related services, and transportation to medical appointments.
- KePRO shall process waiver enrollments and prior authorize services for the AIDS and EDCD waivers.
- DMAS shall process waiver enrollments for the DD waiver and KePRO shall prior authorize services for this waiver.
- DMAS shall process waiver enrollments and prior authorize services for the Alzheimers waiver.
- DMHMRSAS shall process waiver enrollments and prior authorize services for the MR and Day Support waiver.
- Doral Dental shall PA all dental related services.
- LogistiCare shall PA all waiver related services.
- PPL shall process consumer directed timesheets and payroll.

How will providers handle appeals?

The current appeals processes remain in place. Provider appeals shall be handled as follows:

- Acute and primary medical services denied by the MCO shall be appealed through the recipient's assigned MCO.
- Waiver services denied by KePRO shall be appealed through KePRO.

Enrollees shall follow the current process for appeals and enrollees shall still be allowed to appeal to the MCO and DMAS concurrently.

Who do providers call for help?

For questions related to acute and primary medical services, the provider should contact the recipients assigned MCO as noted on their medical ID card.

Providers should contact the DMAS Helpline for questions related to waiver services. The "HELPLINE" is available to answer questions Monday through Friday from 8:30 a.m. to 4:30 p.m., except on state holidays. The "HELPLINE" numbers are:

1-804-786-6273 Richmond area and out-of-state long distance
1-800-552-8627 All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

Questions about the program also may be sent via email to ALTC@dmas.virginia.gov. Information also is at the DMAS website at http://www.dmas.virginia.gov/altc-home.htm

In order to facilitate this transition, DMAS will hire two designated staff members to address any questions or issues that arise regarding authorization, coverage, and provision of services, and to work with the MCOs to coordinate care between providers and the MCOs.